Adult Day Health Care Services

Definition: Adult Day Health services are furnished 5 or more hours per day on a regularly scheduled basis for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. This service is provided to consumers who are eighteen (18) or older. The objective of this service is to restore, maintain, and promote the health status of an individual through the provision of ambulatory health care and health-related supportive services. Physical, occupational and speech therapies indicated in the individual's plan are not furnished as component parts of this service, but may be provided by enrolled physical, occupational, and/or speech therapy providers at the Adult Day Health Care Center as separate services.

Providers: Centers/agencies enrolled with SCDHHS to provide Adult Day Health Care Services under the MR/RD Waiver. These centers/agencies are listed on the Adult Day Health Provider Listing or you may contact your supervisor if you have questions about a center's/agency's enrollment status.

Arranging for the Services: Adult Day Health services are only appropriate for those MR/RD Waiver recipients who, due to functional ability or medical condition, will not benefit from traditional SCDDSN Day Service options. If you believe Adult Day Health services may be needed or if these services are requested by the recipient or his/her family, you will be required to have the need assessed. The **Adult Day Health Care—Assessment of Need (MR/RD Form AA)** should be used to determine if Adult Day Health Care Services are needed. This form must be completed by a licensed nurse/physician and the need for services indicated before Adult Day Health Services can be provided.

Please note: If the intended recipient is currently enrolled in the Elderly and Disabled Waiver and receiving Adult Day Health Care Services, they may or may not be able to continue this service under the MR/RD Waiver. The **Adult Day Health Care—Assessment of Need (MR/RD Form AA)** must be completed and submitted to SCDDSN Central Office along with supporting documentation. If the intended recipient meets the Assessment of Need and the need for Adult Day Health Care is supported by their plan and other submitted documentation, then they will be able to receive this service through the MR/RD Waiver. Typically this type of review if done when submitting the budget. Since this may determine if a consumer chooses to transition from the Elderly and Disabled Waiver to the MR/RD Waiver, you can notify your MR/RD Waiver Coordinator to request a preliminary review and decision prior to MR/RD Waiver enrollment.

Once it is determined that Adult Day Health services are needed, you should document the need for the services in the recipient's plan and provide the recipient or his/her family with the listing of enrolled providers. You should assist the family as needed or requested in choosing a provider and document that you offered a choice of providers.

Prior to starting the service or at the time the service begins, you must provide the Adult Day Health center/agency with a **physician's order** for the service (**MR/RD Form 15-A**), a physical examination report dated not more than 60 days prior to the date services begin, and the physicians recommendations regarding limitations of activities, special diet and medications. (see **MR/RD Form 15-A**).

Once the amount and frequency of the service has been determined and the family has selected a provider, the chosen provider should be contacted to determine space/service availability. Also, at this point, budget information can be entered into the Waiver Tracking System (S79). Once entered, the completed **Assessment of Need (MR/RD Form AA)** and supporting documents (i.e. single plan, medical assessments, psychological evaluation, etc.) must be forwarded to your Regional MR/RD Waiver Coordinator. See Chapter for contact information for your Regional MR/RD Waiver Coordinator. The supporting documents should include information that reinforces the assessment of need.

Once approved, you can authorize the service. For Adult Day Health Care, one unit equals one "client day" which is a minimum of 5 hours per day excluding transportation time. If the recipient's condition so warrants, a "client day" may be less than 5 hours. If the recipient requires less than 5 hours per day, the total hours per day must be noted on the **MR/RD Form A-23 or A-24**. For recipients receiving MR/RD Waiver funded Residential Habilitation, Adult Day Health Services are authorized using the **MR/RD Form A-24** which instructs the provider to bill the DSN Board for services rendered. The **MR/RD Form A-23** must be used **for all other recipients**. The **MR/RD Form A-23** instructs the provider to bill Medicaid for services rendered.

If the DSN Board is licensed as an Adult Day Health provider, no authorization is needed. The Adult Day Health professionals will report the services rendered using the Service Provision Log (SPL).

Once the center/agency receives the completed **MR/RD Form A-23 or A-24** the center or agency must negotiate the start date with you. The **MR/RD Form A-23 or A-24** will remain in effect until a new form changing the authorization is provided to the Adult Day Health Care agency or until services are terminated.

Monitoring the Services: You must monitor the effectiveness, frequency, duration, benefits, and usefulness of the service along with the recipient's/family's satisfaction with the service. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following criteria should be followed when monitoring Adult Day Health Care Services:

- Must complete on-site Monitorship during the first month while the service is being provided
- At least once during the second month of service
- At least quarterly thereafter
- Yearly on-site monitorship required

This service may be monitored during a contact with the individual/family or service provider. It may also occur during review of written documentation at the Adult Day Care Center or during an on-sight visit. Some items to consider during monitorship include:

→ Is the individual satisfied with the Adult Day Health Care Center?
→ Is the ADHC Center clean (sanitary)?
→ Is the ADHC Center in good repair?
→ How often does the individual attend? If less than five hours a day, is this authorized?
→ Are there any health/safety issues?
→ Is PT, OT, or Speech therapy needed?
→ How often does the ADHC Center Staff have contact with family?
→ Are there any behavior problems?
→ What type of recreational activities does the person participate in?
→ What types of recreational activities does the ADHC Center offer?
→ Does the individual feel comfortable interacting with staff?
→ What are the opportunities for choice given to the individual?
→ What type of care is the individual receiving?

Reduction, Suspension, or Termination of Services: If services are to be reduced, suspended, or terminated, a written notice must be forwarded to the consumer or his/her legal guardian including the details regarding the change(s) in service, allowance for appeal, and a ten (10) calendar day waiting period before proceeding with the reduction, suspension, or termination of the waiver service(s). The general termination form that has been used in the past for all waiver services is no longer used. See *Chapter 9* for specific details and procedures regarding written notification and the appeals process.

ADULT DAY HEALTH
ASSESSMENT OF NEED

NAME: _____

SSN: _____

Place a check (Ö) beside the statement that best describes the person's abilities or condition. All responses must be substantiated by current professional reports. To be determined to need Adult Day Health services, the person must score "Yes" on at least one of the bolded questions. The "Yes" must be based on the responses given to the non-bolded questions in the section.

I. Functional Ability (*Check all that apply)*

_____ This person requires extensive assistance (hands-on) with locomotion or transfer **and,** due to the degree of assistance required, he/she cannot benefit from training to develop, improve or enhance self help, socialization or adaptive skills; benefit from interventions designed to prevent loss of previously learned self help, socialization or adaptive skills **nor** will he/she benefit from training or interventions designed to prepare him/her for paid or unpaid employment. (NOTE: Extensive assistance means the person needs hands-on, human assistance for ambulation when appropriate devices/equipment are in use or needs human assistance to propel and direct a wheelchair. This may also be scored "yes" when continuous eye contact must be maintained and intervention provided to prevent wandering).

_____ This person requires extensive assistance (hands-on) with dressing and toileting and eating. (Check only if assistance is needed in all three areas) **and,** due to the degree of assistance required, he/she cannot benefit from training to develop, improve or enhance self help, socialization or adaptive skills; benefit from interventions designed to prevent loss of previously learned self help, socialization or adaptive skills **nor** will he/she benefit from training or interventions designed to prepare him/her for paid or unpaid employment. (NOTE: Extensive assistance means the person may perform part of the activity but needs human assistance to complete at least 50% or more of the task. Dressing in this case refers to adjusting clothes after toileting or donning clean clothes; dressing does not include clothing selection; toileting refers to using a commode, bedpan, or urinal without accident and cleaning self after use; eating refers to setting up prior to the meal as well as food consumption. Table manners or etiquette is not considered part of this.)

_____ This person requires frequent (hands-on) bladder or bowel incontinence care; or with daily catheter or ostomy care **and,** due to the degree of assistance required, he/she cannot benefit from training to develop, improve or enhance self help, socialization or adaptive skills; benefit from interventions designed to prevent loss of previously learned self help, socialization or adaptive skills **nor** will he/she benefit from training or interventions designed to prepare him/her for paid or unpaid employment. (Note: the person my have some control or may be able to assist in some ways but generally requires human assistance for diaper change, toileting schedule, or catheter or ostomy care).

Based on this information, does this person have a functional deficit which prevents him/her from benefiting from day habilitation or prevocational skills training.

YES ☐ **NO** ☐

II. Medical Condition (*Check all that apply.)*

_____ This person requires daily monitoring/observation and assessment due to an unstable (not managed by routine medications and likely to change rapidly) medical condition which may include overall management and evaluation of a medical care plan which changes daily or several times a week. (May include but are not limited to conditions such as those related to heart/circulation [hypertension, heart disease], sensory, neurological [seizures], psychiatric/mood, pulmonary [emphysema, cystic fibrosis], skin [decubiti], or others [diabetes, cancer, etc.])

_____ This person requires administration of multiple medications which require frequent dosage adjustment, regulation and monitoring (e.g. medications are given or held based on current conditions such as pulse rate or glucometer readings, etc.).

_____ This person requires administration of parenteral (not given by mouth) medications and fluids which require frequent dosage adjustment, regulation, and monitoring. (Routine injections scheduled daily or less frequently, such as insulin injections, do not qualify).

_____ This person requires special catheter care (e.g., frequent irrigation, irrigation with special medications, frequent catherterizations for specific problems).

_____ This person requires treatment for extensive decubitus ulcers or other widespread skin disorder.

_____ This person requires nasogastric tube or gastronomy feedings.

_____ This person requires nasopharyngeal or tracheostomy aspirations or sterile tracheostomy care.

_____ This person requires administration of medical gases (e.g. oxygen).

_____ This person requires daily skilled monitoring or observation for conditions that do not ordinarily require skilled care, but because of the combination of conditions, may result in special medical complications.

Based on this information, this person needs skilled services due to his/her complex medical needs.

YES ☐ **NO** ☐

SIGNATURE OF ASSESSOR _____ _____

Licensed Nurse Date

LICENSE NUMBER: _____

Attach copies of the professional reports substantiating the information on this assessment.

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

MR/RD WAIVER

PHYSICIAN'S ORDER
FOR
ADULT DAY HEALTH SERVICES

Participant's Name: _____

Date of Birth: _____

SSN: | | | | | | | | | |

I hereby order Adult Day Health Services to be provided to the above named person with the following limitations of activities: _____

_____

This person requires the following diet: _____

_____

This person requires the following medication: _____

_____

A physical examination report must be attached.

_____

Physician's Name Telephone #

_____

Address

_____ _____

Physician's Signature Date

NOTE: Must be completed within 60 days of admission to ADHC.

MR/RD Form 15-A (8/99)

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE BILLED TO SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

TO: _____

_____

RE: _____
Recipient's Name / Date of Birth

_____
Address

Medicaid # /___/___/___/___/___/___/___/___/___/___/___/

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # /_____/_____/_____/_____/_____/_____/_____/_____

Adult Day Health Care Services (X6987)

Number of Units Per Week :_____ one unit = 1 (5 hour) day

Start Date:_____

OR

The above named recipient cannot tolerate a 5 hour day. Therefore you are authorized to provide:
Number of Units Per Week :_____ (one unit = _____ hours per day)
Start Date:_____

Service coordinator: Name / Address / Phone # (Please Print):

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE *BILLED TO DSN BOARD*

TO: _____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

Medicaid # /___/___/___/___/___/___/___/___/___/___/___/

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Adult Day Health Care Services

Number of Units Per Week :_____ (one unit = 1 (5 hour) day
Start Date:_____

OR

The above named recipient cannot tolerate a 5 hour day. Therefore you are authorized to provide:
Number of Units Per Week :_____ (one unit = _____ hours per day)
Start Date:_____

REMIT BILL TO (Please print):

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

MR/RD Form A-24 (8/01)

MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
ADULT DAY HEALTH CARE SERVICES

A. Objective

The objective of Adult Day Health Care (ADHC) Services is to restore, maintain, and promote the health status of Medicaid home and community-based waiver clients through the provision of ambulatory health care and health-related supportive services in an ADHC center.

B. Conditions of Participation

1. The ADHC provider must maintain a current Adult Day Care license from the Department of Health and Environmental Control (DHEC) or equivalent licensing agency for an out-of-state provider.

2. The ADHC provider must have on staff a Nursing Supervisor with the following qualifications:

   a. Registered Nurse (RN) currently licensed by the S.C. State Board of Nursing or appropriate licensing authority of the state in which the ADHC provider is located for an out-of-state provider; and

   b. minimum of three years experience in a related health or social services program; and

   c. minimum of one year administrative or supervisory experience.

   3. For ADHC providers with 61 or more home and community based waiver clients who employ a case manager to meet staffing requirements of section D. 3 and D.4, the case manager must have a bachelor's degree in health or human science with case management study.

Any deviation from these conditions of participation must be prior approved in writing by the Director, Division of Community Long Term Care Waiver Management (CLTC), South Carolina Department of Health and Human Services (SCDHHS).

C. Description of Services to Be Provided

1. The Unit of Service will be a client-day of ADHC services consisting of a minimum of five hours at the center. The five hours does not include transportation time. For individuals authorized under the Mental Retardation/Related Disabilities (MR/RD) waiver, the client-day may be less if the individual's condition so warrants and the provider is advised accordingly on the DDSN service authorization.

2. The ADHC center must be open Monday through Friday at least eight hours a day. The hours of operation may be any eight hours between 7:00 am and 6:00 pm. The Provider shall provide to SCDHHS, Division of CLTC a list of regularly scheduled holidays and the Provider shall not be required to furnish services on those days. Any deviation in hours or days of operation during the contract period requires prior approval by the SCDHHS, Director, Division of CLTC Waiver Management.

3. The number of days a client attends each week is determined through the Medicaid home and community-based waiver service plan and indicated on the service authorization.

4. The Provider must either provide directly, or make sub-contractual arrangements for some but not all of the following non-billable services which are included in the daily rate:

   a. Daily Nursing Services performed by an RN or under the supervision of an RN as permissible under State law to monitor vital signs as needed; to observe the functional level of the client and note any changes in the physical condition of each client; to supervise the administration of medications and observe for possible reactions; to teach positive health measures and encourage self-care; to coordinate treatment plans with the physician, therapist, and other involved service delivery agencies; to supervise the development and implementation of a care plan; to appropriately report to the client's physician and/or the Case Manager/Service Coordinator any changes in the client's condition. Documentation of service provision must be approved by the RN.

   b. Supervision of, Assistance with and Training in Personal Care and Activities of Daily Living including dressing, personal hygiene, grooming, bathing and maintenance of clothing.

   c. Daily Planned Therapeutic Activities to stimulate mental activity, communication and self-expression. These include reality orientation exercises, crafts, music, educational and cultural programs, games, etc.

   d. One Meal and a Snack per day with the meal meeting 1/3 of the daily recommended dietary allowances (RDA) for this age group as adopted by United States Department of Agriculture. Special diets prescribed by the attending physician must be planned and prepared with consultation from a registered dietitian as needed.

   e. Client Transportation to and from the center must be provided by the Provider for all clients who reside within fifteen (15) miles of the center using the most direct route door to door from the center to the client’s place of residence or other location as agreed to by the provider and as indicated on the service authorization. The mode of transportation must be an enclosed vehicle with adequate ventilation, heat and provision for wheelchair bound clients.

      The Provider will provide assistance to the client from the door of the client's residence to the vehicle and from the vehicle to the door of the client's residence or other location as agreed to by the provider and as indicated on the service authorization.

5. The Provider must provide space within the adult day care center for the provision of physical, speech, and occupational therapy services.

6. The Provider will incorporate in the procedures for operation of the center adequate safeguards to protect the health and safety of the clients in the event of a medical or other emergency.

D. Staffing

The minimum staff requirements must be consistent with licensing requirements (one direct-care staff for every eight participants). In addition to the minimum staffing standards required by licensing, whenever

home and community-based waiver clients are present the following staffing standards for nurses and case managers apply. All nurse staffing and care must be provided within the scope of the South Carolina Nurse Practice Act. Should the RN position become vacant, the ADHC Provider must notify the local CLTC office no later than the next business day. Any deviations from these staffing patterns must be approved in writing by the (SCDHHS), Director, Division of CLTC Waiver Management.

1. For 1-35 home and community-based waiver ADHC clients: one RN must be present as follows:

1 – 10 clients	2 hours minimum
11 – 20 clients	3 hours minimum
21 – 25 clients	4 hours minimum
26 – 35 clients	5 hours minimum

2. For 36 – 60 home and community-based waiver ADHC clients: one RN and one additional RN or LPN must be present for a minimum of five hours. A licensed nurse must be present whenever home and community-based waiver clients are present

3. For 61 – 90 home and community-based waiver ADHC clients:
   a. one RN and two additional RNs or LPNs; or
   b. one RN, one additional RN or LPN and one case manager.

   Required nursing and case management staff must be present for a minimum of five hours. A licensed nurse must be present whenever home and community-based waiver clients are present.
4. For 91-or more home and community-based waiver ADHC clients:
   a. one RN and three additional RNs or LPNs; or,
   b. one RN, and two additional RNs or LPNs and one case manager.

   Required nursing and case management staff must be present for a minimum of five hours. A licensed nurse must be present whenever home and community-based waiver clients are present.

5. PPD Tuberculin Test

   No more than ninety (90) days prior to employment, all staff having direct client contact shall have a PPD tuberculin skin test, unless a previously positive reaction can be documented. The two-step procedure is advisable for initial testing in those who are new employees in order to establish a reliable baseline. [If the reaction to the first test is classified as negative, a second test should be given one to three weeks after the first test. If the second test is classified as negative, the person is considered as being uninfected. A positive reaction to a third test (with an increase of more than 10mm) in such a person within the next few years, is likely to represent the occurrence of infection with M. Tuberculosis in the interval. If the reaction to the second of the initial two tests is positive, this probably represents a boosted reaction, and the person should be considered as being infected.]

   Employees with reactions of 10mm and over to the pre-employment tuberculin test, those with newly converted skin tests, and those with symptoms suggestive of tuberculosis (e.g., cough, weight loss, night sweats, fever, etc.) regardless of skin test status, shall be given a chest radiograph to determine whether tuberculosis disease is present. If tuberculosis is diagnosed, appropriate treatment must be given, and the person must not be allowed to work until declared noncontagious by a licensed physician.

   Routine chest radiographs are not required on employees who are asymptomatic with negative tuberculin skin tests.

Employees with negative tuberculin skin tests shall have an annual tuberculin skin test.

New employees who have a history of tuberculosis disease and have had adequate treatment shall be required to have certification by a licensed physician or local health department TB staff (prior to employment and annually) that they are not contagious. Regular employees who are known or suspected to have tuberculosis shall be required to be evaluated by a licensed physician or local health department TB staff, and must not return to work until they have been declared noncontagious.

Preventive treatment should be considered for all infected employees having direct client contact who are skin test positive but show no symptoms of tuberculosis. Routine annual chest radiographs are not a substitute for preventive treatment. Employees who complete treatment, either for disease or infection, are exempt from further routine radiographic screening, unless they develop symptoms of tuberculosis. Employees who do not complete adequate preventive therapy should have an annual assessment for symptoms of tuberculosis.

Post exposure skin tests should be provided for tuberculin negative employees within twelve (12) weeks after termination of contact to a documented case of infection.

Providers needing additional information should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, S.C. 29201 (phone (803) 898-0558).

6. Personnel Records

Provider must maintain individual personnel records, for each employee, including contracted personnel, which document the qualifications necessary to meet part C.4 and D of this contract.

E. Conduct of Services

1. The Provider will initiate ADHC services on the date negotiated with the Case Manager/Service Coordinator and indicated the Medicaid home and community-based waiver authorization. Services must not be provided prior to the authorized start date.

2. The Provider will notify the Case Manager/Service Coordinator within three (3) working days of the following client changes:

   a. Client's condition has changed or the client no longer appears to need ADHC services.

   b. Client is institutionalized, dies or moves out of service area.

   c. Client no longer wishes to participate in ADHC services.

   d. Knowledge of the client's Medicaid ineligibility or potential ineligibility.

3. The Provider will maintain a record keeping system which establishes a client profile in support of the units of ADHC services delivered, based on the Medicaid home and community-based

waiver authorization. Individual client records must be maintained and contain the Medicaid home and community-based waiver authorization, the ADHC's care plan (which is approved and signed by the RN), the Medicaid home and community-based waiver CLTC Mode of Transportation form, the Physician Orders(DHHS Form 122), and all care and services provided. In addition, for CLTC authorized services, the ADHC care plan must be based on the CLTC Service Plan and the CLTC Service Plan must be maintained in the client record.

4. Providers must have a daily schedule/activity plan that provides for the delivery of all required services to all clients based on the day's actual census.

5. The Provider will develop and maintain a Policy and Procedure Manual which describes how activities will be performed in accordance with the terms of the contract.

6. The Case Manager/Service Coordinator will review a client's needs within three (3) working days of receipt of a written request from the Provider to modify the CLTC Service Plan/DDSN Service Authorization.

7. The Case Manager/Service Coordinator will request ADHC services by authorizing the amount, duration and frequency of service for clients in accordance with the client's needs.

8. The Case Manager/Service Coordinator will obtain the signed and dated physician's order for ADHC and a physical examination report (SCDHHS Form #122), that is not over sixty (60) days old. The report must include recommendations regarding limitations of activities, special diet, and medications. This will be sent to the provider prior to or at the time of admission to ADHC. Subsequent physical examinations or periodic health screening to determine the client's ability to continue in the program will be required at least every two years. The ADHC Provider will be responsible for procuring the subsequent physical examination reports.

9. The Case Manager/Service Coordinator will notify the Provider immediately if a client becomes medically ineligible for Medicaid home and community-based waiver services. The Case Manager/Service Coordinator will make every effort to verify Medicaid eligibility on a monthly basis. However, the Provider should refer to the language in the Community Long Term Care Services Provider Manual on page 1-5 regarding the provider's responsibility in checking the client's Medicaid card.

10. All CLTC client absences must be reported in writing to the local CLTC Area Office on Friday of each week.

F. Administrative Requirements

1. The Provider agency shall designate an individual to serve as the agency administrator. This does not have to be a full time position; however, the designated administrator must have the authority and responsibility for the direction of the Provider agency. The Provider agency shall notify SCDHHS within three working days in the event of a change in the agency Administrator, address, or telephone number.

2. The organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on client care level staff shall be set forth in writing. This shall be readily accessible to all staff and shall include an organizational chart. A copy of this shall be forwarded

to SCDHHS at the time the contract is implemented. Any future revisions or modifications shall be distributed to all staff of the Provider agency and to SCDHHS.

3. The Provider agency must have written bylaws or equivalent which are defined as "a set of rules adopted by the Provider agency for governing the agency's operations." Such bylaws or equivalent shall be made readily available to staff of the Provider agency and shall be provided to SCDHHS upon request.

4. Administrative and supervisory functions shall not be delegated to another agency or organization.

5. A governing body or designated persons so functioning shall assume full legal authority for the operation of the Provider agency. A listing of the members of the governing body shall be made available to SCDHHS upon request.
6. An annual operating budget, including all anticipated revenue and expenses related to items which would under generally accepted accounting principles be considered revenue and expense items, must be submitted to SCDHHS prior to the signing of the initial contract with SCDHHS. The Provider agency must maintain an annual operating budget which shall be made available to SCDHHS upon request.

7. The Provider agency shall acquire and maintain during the life of the contract liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the agency. Upon request, the Provider agency shall furnish a copy of the insurance policy to SCDHHS.